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TRIP REPORT 904

KYRGYZSTAN UPDATE: FAMILY GROUP PRACTICE, HEALTH INSURANCE FUND, AND LICENSING & ACCREDITATION

September 28-October 18, 1997

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1.0 EXECUTIVE SUMMARY

The health system of the Republic of Kyrgyzstan is undergoing a major transition from the traditional Soviet model, dominated by medical specialists, to a primary care-oriented family medicine delivery system. Its Republican Health Insurance Fund (HIF) is implementing capitation to pay for the medical care of the population using family practices, a per case payment system for hospitals, and a fee schedule for polyclinic specialty care. This rapidly changing system also is developing and implementing a health facility licensing and accreditation (L&A) process, and an effective family group practice (FGP) network.

The overall objective of the consultant's visit to Kyrgyzstan was to continue to assist the building process of these three components of health reform. More specifically, he was to:

- assist counterparts with the development of an effective L&A process;
- assist with FGP and FGP Association (FGPA) development and implementation; and
- continue implementation of the outpatient payment systems.

He also was asked to review the Issyk-Kul oblast Intensive Demonstration Site (IDS) project implementation.

In response, the consultant:

- Carried out an extensive review of the activities in the Karakol IDS, listing findings and recommendations; and

- Conducted education and training programs/workshops for counterparts in the L&A and FGP components of the project.

Each of the consultant's tasks and his findings and recommendations for follow-up is described individually in Section 5.0. His proposals for FGPA development, capitation for FGPs, and a joint computer/shared services operation, as well as workshop agenda, are in the report annexes.

2.0 BACKGROUND

This trip report describes the Zdrav*Reform* consulting work carried out during the period September 28-October 18, 1997, in conjunction and coordination with the World Bank Project on Health Reform. It was the consultant's third major consulting visit to Bishkek, the capital of Kyrgyzstan, and eighth trip to the Issyk-Kul oblast Intensive Demonstration Site (IDS), based in the city of Karakol. The major focus of this trip was the continuing design, development, and implementation of licensing and accreditation (L&A) process for health care facilities throughout Kyrgyzstan, as follow-up to the work done in the

Issyk-Kul oblast IDS. A number of previous reports on the overall developmental needs of the health system in Kyrgyzstan were carried out during 1994-97, and are listed in the Reference Section in Annex 5.

Prior to June 1997, the Zdrav*Reform* Issyk-Kul IDS was managed by a long-term expatriate consultant. That person advisor was subsequently replaced by a locally hired advisor.

3.0 OBJECTIVES

The scope of work, major objectives, tasks and outputs for this consultant were as follows:

- Continue Zdrav*Reform* assistance to the process of design, development, and implementation of the L&A and family group practices (FGP) processes for Kyrgyzstan;

- Conduct an in-depth review of the Health Insurance Fund (HIF) and FGP development and implementation process in the Issyk-Kul IDS; and

- Develop proposals for FGP Association Board/Management Development, FGP capitation fundholding, and a Joint Computer/Shared Service Operation between the oblast health department and HIF.

4.0 ACTIVITIES

The consultant's daily activities are described in Annex 1.

5.0 FINDINGS AND RECOMMENDATIONS

5.1 Family Group Practice

5.1.1 Background

The development of FGPs in Kyrgyzstan has been well documented (see Reference Section). The Zdrav*Reform* Issyk-Kul IDS and the Government of Kyrgyzstan's Issyk-Kul "Experiment" have been under development and implementation since 1994. Considerable effort and resources, including training, instruments, equipment, management, renovations and facilities, have been focused into the development of effective FGPs in Karakol during the period 1995-97 and is on-going. The success of the Issyk-Kul experience is now being rolled out with the assistance of the World Bank to other oblasts of Kyrgyzstan. The consultant was requested to follow up on the activities

in Karakol, and to update management on the progress and problems of the present environment.

5.1.2 Update

The transition of many of the staff from the Karakol IDS to the Bishkek project and the departure of the expatriate IDS manager has been completed. Karakol is once again running smoothly and will provide the experimental environment needed for the roll-out of the World Bank Project. The new local-hire IDS manager is effective, and with some management advisory assistance from Tom George (the local-hire consultant), has settled nicely into the new position. Much progress has been made over the last four months.

The average FGP enrollment figure for the Issyk-Kul oblast population is 80 to 90 pecent. Enrollment is approximately 93 percent in Karakol (62,000 population) and approximately 86 percent in the rest of the oblast (427,000 population). This is excellent for this stage of the project. The 67 FGPs in rural rayons have lately had more attention from the local Zrav*Reform* staff and are beginning to perform more effectively. Remaining problems in some distant rural areas are being handled on a timely basis.

FGP Practice Manager (PM) supervision has been improved, especially in Karakol, with the appointment of a PM supervisor who directly oversees the 14 FGPs in Karakol and, less directly, the 67 rural FGPs, which employ a total of 28 PMs. Most FGPs have business plans and are using the CIS data form correctly, and most PMs are inputting the data form in a timely manner. Rural FGPs need more rigorous supervision and control, but they present too extensive a geographical area for one person to oversee thoroughly. With the coming of capitation, the demands will only increase.

For this reason, a good case could be made for additional supervision in the rural areas, and this needs to be discussed in the near future. The consultant recommends two new supervisory positions, one for the north side of Lake Issyk-Kul (possibly in Cholpon-Ata), and one for the south side of the lake (possibly in Ton); the existing supervisory position would then cover the large population at the east end of the lake. These need not be additional positions but rather the extension of responsibilities for two existing, along with some realignment of FGP coverage responsibilities. PMs and FGPs will operate effectively and efficiently only if management oversight is strong and constant..

Marketing activities continue to move forward on a number of issues. Family planning and infectious disease information and training has been a high priority. Some efforts to end self-referrals have been made, but no data are available to judge whether any change has occurred. Plans are underway to do re-enrollment during a two-week period in December, to allow families to change FGPs. It is estimated that only approximately 5 percent of families will change, mainly in the two cities of Karakol and Bayluchi. At this point there is no monthly list of changes in FGP enrollment; this must become a priority as the funding systems change.

5.1.3 Recommendations for Follow-up

The Karakol IDS management will need to follow up on the items listed below:

1. The Marketing Group in Karakol presently focuses most of its efforts on family planning and infectious disease communication. The group should begin to expand its focus to include plans for marketing and information dissemination of the coming changes in the HIF payment system. A major marketing effort and associated resources also are needed for the critical issue of reducing the self-referrals to hospitals and polyclinics. There is a need for a self-referral data collection system to see if the problem is improving or if it is getting worse. A monthly report on changes in FGP enrollment will need to be developed and in place by January 1, 1998, in order to note increases or decreases due to families moving into or out of the area. This will directly affect capitation payments.

2. The utilization of new software reports for the MIS/CIS input\output analysis should be made a greater priority, because the need for correct data for decision making with respect to FGPs is very important. PMs and eventually the HIF must begin to utilize the reports.

3. The future procurement of instruments and equipment should ensure that quality items are purchased. This consultant found on visits to the FGPs that many of the medical instruments and equipment procured earlier were of poor quality items and broke readily. This included stethoscopes and blood pressure instruments as well as baby weighing scales. (This recommendation is repeated from the consultant's June trip report.)

4. As noted above, the issue of self-referrals is a major problem and will need not only marketing assistance but some type of negative incentive, such as a user fee for patients who bypass the primary care physician and self-refer to a specialist. (This also is repeated from the June trip report.)

5. Feedback and daily corrections to FGPs on the filling out of the "Purvis forms" and input to the MIS/CIS computer system should continue to be a high priority for PMs.

6. A review of the progress of the PMs on the development of FGP business plans has shown that some action has been taken primarily in the Karakol area However, there is still much to be done, especially in the rural areas. With a capitation system coming, this should become a priority.

7. While the PM's have in general been a success, there is still much to be desired in their overall direction and supervision, especially in the rural areas. It is strongly recommended that two FGP Practice Manager Rural Supervisor positions be created. These should be full-time positions, but they need not be additonal positions, rather only a realignment of responsiblities. The persons selected to fill these positions will ideally have an automobile or access to transportation. The rural PMs need continual, full-time

planning and control of their activities, time, and behavior. This should be a first-level management priority.

5.2 Family Group Practice Association

5.2.1 Background

The process of developing an effective Family Group Practice Association has been underway for a number of years and is well documented elsewhere.

5.2.2 Update

There are presently two associations in the Karakol area, and plans are underway to merge them into a single association for the entire oblast. The legal work is presently being done to complete this task, and the consultant spent time with the Zdrav*Reform* attorney to prepare the way for this to happen in the near future.

With the implementation of the new FGP Association, there will be a need for a new board and management structure. A proposal for development of this new structure is outlined in Annex 2.

5.2.3 Recommendations for Follow-up

Outlined below are a number of developmental activities which should be completed during the initial stages of development of the FGPA:

1. Board membership will need to be decided and should probably be kept small, at not more than nine to eleven members.

2. The structure and membership for board committees and subcommittees needs to be outlined and developed.

3. Board committees should consist of the normal oversight functions of finance, quality assurance, audit (both medical and financial), community/public relations, and others as the need develops, as well as a small (three-person) executive committee for timely decision making when the full board cannot meet.

4. The board should probably have a non-voting position of "secretary to the board" to oversee, organize, distribute, and follow up on agendas, meetings, board papers, and other administrative functions of the board.

5. Board committees and subcommittees should be kept small, with five to seven persons as official representatives and various staff added as unofficial members.

6. The board should consider having at least one member of the Mandatory Health Insurance Fund board, in order to provide feedback to the Fund's board on policy issues.

7. A workshop in improving board/management effectiveness should be scheduled to get the new board and management off to a good start.

8. Other organizational and staffing issues are the development of job/position descriptions for all of the new and proposed positions for the board.

9. A key issue will be who and how many management personnel there will be and how they will be paid during the start-up.

10. Important tasks in the management area are the development of position descriptions, functions, and responsibilities of management committees and subcommittees.

11. Board/management issues, such as distinguishing the different roles, responsibilities and authority of each element of the governance/management process, must be defined.

l2. Management will also need to begin thinking about strategic issues, and it is not too early to consider a board/management retreat to do strategic planning.

13. One key task in the finance area is the development of a "Sources and Uses of Funds" document, which serves as the board's major financial forecasting and reporting vehicle.

5.3 Mandatory Health Insurance Fund/Joint Computer Operations

5.3.1 Background

The development of the Mandatory Health Insurance Fund (MHIF) in Issyk-Kul oblast has been in various stages of implementation since 1994 and the history is well documented (see Reference Section). While a single payer system was originally envisioned for the oblast and the country as a whole, economic and political issues made this unachievable. What has evolved over the last year is a two payer system with the MHIF paying for the employed population and the Ministry of Finance, through the Ministry of Health (MOH), paying for the non-employed population.

The Issyk-Kul MHIF is presently operating with a start-up staff and has actually made some payments to the Oblast Hospital based on a per case payment system developed and implemented with the assistance of the Zdrav*Reform* Program. The MOH continues to make selected payments, mostly salaries, as funds become available.

The two payer system which has evolved has agreed that some services will be shared between the MHIF and the MOH. The exact services to be shared have not been explicitly agreed to in writing, but the general agreement is that Information Systems (IS) will be shared and that both parties will have one set of data systems, including a Joint Computer

System. The details of all of the shared services, functions, staffing, authorities, responsibilities, etc. is still to be worked out over the coming months.

5.3.2 Update

The consultant reviewed the existing operations and discussing with key staff the present and possible future operation of the Joint Computer/Shared Services Operations (JCSSO). Outlined in Annex 3 is a proposal for the setting up, organization, staffing, development, and implementation of this Joint Operation.

The case based payment for hospitals is apparently working effectively, in the beginning stages, as the Oblast Health Insurance Fund is apparently making some payments to the Oblast Hospital based on the Zdrav*Reform*-developed input case based information sheets. Although time was not available during this trip to review the area in depth, it will be a high priority next visit, because it is important to verify that this is actually happening and if it is happening correctly. A review of the other major rayon and oblast hospitals to see if they are doing the same, should be a high priority.

Another area of highest priority should be the development of the outpatient fee schedule for polyclinics. While some work has been done on this, the responsible party has departed, and little or no back-up information is available. Zdrav*Reform* has assigned personnel to this task and made it a high priority for the next three months. It must be completed prior to the partial capitation fundholding system scheduled to begin in early 1998.

In general, HIF development is progressing as planned with few major problems. The fact that the HIF has actually been established and has made some payments speaks for itself .

5.3.3 Recommendations for Follow-up

Outlined below are some of the many remaining issues and concerns to be discussed and agreed upon for the set-up and operation of the JCSSO:

1. Staffing and funding issues for each position;

2. Positions to be transferred from the OHD;

3. Supervision of the operation, if required;

4. A list of equipment to be transferred to the new location;

5. Data elements and various reports for each major component (health facility)

6. The various legal structure for the operation;

7. The accounting and finance duties, responsibilities and authorities; and

8. The various reporting relationships to the MOH, OSF, and other related organizations.

5.4 FGP Capitation Fundholding

5.4.1 Background

FGP capitation fundholding was originally developed in Great Britain to allow family practitioners more flexibility in the management and utilization of funds for a given patient population. This concept has broad applicability in a number of situations and is being developed and implemented in the Issyk-Kul oblast in conjunction with a case based payment system for hospitals and a fee schedule payment system for polyclinics. A basic objective of the new system is to provide financial incentives to FGPs for more efficacious diagnosis and treatment of patients within their own primary care system, resulting in improved quality of care and lowered overall health care system cost by reducing the number of unnecessary referrals to polyclinics and hospitals for specialty, paraclinical, and inpatient services.

5.4.2 Update

The Issyk-Kul Oblast presently has 83 FGPs covering the entire oblast, both rural and urban. The business side of the FGPs is managed with the assistance of 28 Practice Managers, who have assisted in developing a business plan for each FGP, including enrollment figures, fixed and variable costs as well as direct and indirect expenses, developed from actual 1996-97 experience and a 1997-98 budget.

Significant effort has gone into the development of a variety of options for paying the FGPs based on some capitation arrangement. The calculation of the proposed captitation rate has been developed in three separate components and is discussed in Annex 4. The government of Kyrgyzstan has agree to modify the health budget process to add a new line item in the 1998 budget to allow for primary care expenses, specifically FGP expenses. The capitation fundholding implementation will occur in a low-risk environment with a number of stages so that it can be watched carefully and adjusted for any unusual factors that might occur.

5.4.3 Recommendations for Follow-up

Recommendations are included in the draft described in Annex 4.

5.5 Role of Zdrav*Reform* in Karakol

5.5.1 Background

The development and implementation of a large USAID program requires the contractor to play a variety roles in working with counterparts, with USAID in Almaty and in Washington, and with its own corprate office. The role of Abt Associates, Inc., the prime contractor for the Zdrav*Reform* Program, is one of providing leadership, management, and developmental advice to the host country. Abt Associates is alternately advisor, coordinator, funding source, planning and control agent, fiscal intermediary, and human resource director.

5.5.2 Update

This section defines the relationships between Abt Associates and the Zdrav*Reform* Program, on the one hand, and Central Asian counterpart institutions, on the other.

Oblast Health Department: The OHD, as part of the Ministry of Health, is Zdrav*Reform*'s primary counterpart in the Karakol IDS. Zdrav*Reform* fulfills many roles including fiscal overseer for expenditure of project funds, and catalyst for action. Its major role is as advisor on technical design, planning and implementation of IDS activities.

Family Group Practice Association: The FGPA and its member FGPs are the second major counterpart the main recipients of Program assistance. The restructuring of the health care system is the major change in the project. Again, Zdrav*Reform* plays a variety of roles: in development and operations, as the FGPA lacks experience with association work and with FGP principles, methods, training, equipment, legal issues, or management; in funding the association; in hiring and firing staff; in arranging grants and contracts; and in carrying out planning and control activities. Zdrav*Reform*'s current management role should evolve over time to become advisory, as the FGPA becomes self funding and independent from the OHD.

Oblast Kassa Zdarovia/Mandatory Health Insurance Fund: The OKZ is one of the major new organizations in the health system. Zdrav*Reform*'s role is primarily to give technical advice and some start-up funding.

Joint Computer/Shared Services Operation: The development and implementation of the JCSSO is the major health payment coordination vehicle between the OHD and the OKZ and is meant to serve the needs of both organizations. As this may be a problem relationship in the start-up stage, the Zdrav*Reform* assists with management, operations, staffing, and fiscal oversight.

FGP Center for Excellence: The Center is an affiliate of the STLI Program in Bishkek, but is an integral component of the FGPA. Zdrav*Reform* has contributed to funding and operations; its role should become advisory over time.

5.6 Licensing and Accreditation

5.6.1 Background

The process of establishing a Licensing and Accreditation Program for Kyrgyzstan began in October 1995 with a series of seminars on the process of hospital L&A by an Abt Associates consultant and a representative of one Zdrav*Reform* subcontractor, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), in Bishkek and Karakol. The seminar reviewed the processes and some 500 individual standards used by the JCAHO in accreditation of hospitals in North America.

These seminars were followed up in the Karakol IDS with a consultancy in February 1996 by this consultant which made the North American document more country- and facility-specific and factored in the uniqueness of the CIS countries and the structure and organization of hospitals in the former Soviet Union. This resulted in the elimination of non-relevant sections (Board of Trustees, patient rights, finance, and others) and reduced the 528 individual standards to 307 individual standards which better fit the environment and the existing resource needs.

Additional efforts during 1996 were delayed due to other issues and priorities. With the initiation of the World Bank Health Reform Project and the extension of the Zdrav*Reform* Program, new funds became available to continue the work on the L&A component.

5.6.2. Update

With the World Bank Project on Health Reform, funds became available to hire and train personnel to work on L&A development for hospitals in Kyrgyzstan. Considerable effort has gone into the education and training of a group of technical experts to begin the process of surveys and actual licensing and accreditation of hospitals. During the past three months, the L&A Commission (LAC) has developed standards for both licensing and accreditation, and has licensed and accredited six of the twelve hospitals designated by the MHIF to be completed by the end of 1997.

The consultant was requested to work with this new group to follow up on the work done three months ago on licensing and to critique and follow up with the group on accreditation standards and full implementation country wide of an effective and efficient L&A program.

The consultant met a number of times with the LAC Chairman and the group of L&A technical experts, and he conducted workshops and training programs for this group on the methodology of L&A, and the lessons learned, as well as the consultant's concerns about the materials already developed. (See Annex 7 for the workshop agenda and basic material presented.) A great deal of effort has gone into the development of a effective L&A process, and the consultant's role was to review this material, list concerns and recommendations (based on his work in many other countries), and to offer options for other ways of carrying out specific L&A functions.

As highlighted during the seminar/workshop, the consultant noted a number of areas which need additional review and revision by the LAC experts. The consultant was able to review in depth a number of the survey reports of the seven to eight institutions already surveyed for both licensing and accreditation. Outlined below is a presentation of the possible problem areas, the strengths/accomplishments, and the weaknesses—and recommendations to resolve the problems and weaknesses—of the existing process of L&A.

5.6.3 Findings and Recommendations for Follow-up

Potential Problems: The consultant identified the following potential problems during the course of the one-day workshop held to review the existing process for licensing and accreditation:

- Complexity of the process (size, difficulty, formulas, number of standards, practicality);
- Large number of standards, calculations, formulas, and ratios;
- Inconsistency in scoring and surveyors' ratings of a given standard;
- Errors in scoring and missing scores of some standards;
- Difficulty in understanding and communicating scoring to users;
- Need for clear, concisely writtern statements for each standard;
- Need for clear identification of the compliance document for each standard;
- Difficulty of understanding and communicating the standards to the average facility user;
- Need for definitions of terms in some standards;
- Subjectivity/lack of objectivity of some standards and some criteria;
- Inability to change standards easily over a short period of time;
- Need for a user's advisory group to give feedback and assistance in improving the L&A process.

Strengths/Accomplishments: The consultant identified the following strengths of the existing L&A process.

- The process as a whole is well developed, has good policies and procedures, and is comprehensive and thorough in its presentation of materials, schedules, and reports.

- The process of notification, pre-collection of materials from facilities, scheduling of site visits and actual visit implementation is well developed and implemented.

- The use of external as well as internal experts is an excellent development.

- The development of clear and concise licensing standards with clear identification of confirmation documents is excellent and modifications to the original lcensing

standards list have been made based on the consultant's recommendations and the experience of the L&A Commission.

- The medical records review process is especially well developed.

- The completed reviews and L&A of eight of the twelve planned facilities within the time period shows great determination on part of the LAC.

- Of the first seven facilities reviewed, only one was rated at the 2nd level (50-69 percent; six were rated at the 1st level (70-89 percnet), and none at the highest (90-100 percent) level. This shows that the process is reasonable at the first stage of facilities review. However, considering that these are known to be some of the best facilities in the country, it is hoped that some of the twelve would be rated at the highest level, but this must wait for outcome of all twelve to be completed.

Weaknesses and Recommendations: The consultant identified the following weaknesses in the L&A process, and made recommendations to correct them.

1. *The current L&A process is unnecessarily complex and, as a result, is not readily understandable nor easily communicated to the average facility user.*

Recommendation: The L&A process should be evaluated after the first twelve hospitals are reviewed, to determine if the process can be reduced in complexity. The evaluation committee should be drawn from the LAC, HIF, and the twelve facilities. The evaluation should review the objectives of the process; the ability of the LAC to communicate the process; and the facilities to understand the standards, the compliance criteria, and the timing, scheduling, and procedural process. Accreditation is meant to be an educational process for a facility, resulting in continuous quality improvement. Is this what the present process is focused upon, and is this how the process is being preceived by the user facilities?

2. *The quantity of data collected appears to be excessively large and unnecessary and could be reduced without reducing the effectiveness of the process*.

Recommendation: A review of the quantity of data collection should be carried out to determine if all of this data is necessary to verify the quality improvement process.

3. *The accreditation standards exist only in "outline" format and are not clear or easily understandable to the user facility. A lack objective criteria for measurement leads to surveyor subjectivity in the responses. The compliance documents to be reviewed are not clearly enumerated with the standards*.

Recommendation: Each standard should be written in sentence/statement format with clear, concise descriptions of each element of the standard and the criteria utilized to measure each standard. The compliance criteria, and specifically the documents to be

reviewed to measure compliance with the standard, should be listed with the written description of the standard. More definitions of terms and more objective criteria are needed.

4. *The process of scoring the compliance with each standard is very complex, and in some cases not clear, consistent, or easily understood by the average user. This makes it difficult for surveyors to use and results in wide variations of ratings among surveyors reviewing the same level of compliance. The large quanitities of calculations required to total up the score in each respective category leads to miscalculations and errors in calculation*.

Recommendation: The scoring and rating system should be reduced in complexity and quantity of categories and calculations required, and consistency in the rating system should be improved. Most other countries use a rating system of 2 (full compliance), 1 (partial compliance), and 0 (no compliance). This reduces the numerous formulas, calculations, and scoring problems which result from an unnecessarily complex system.

Follow-up Activities: The L&A Commission has developed its own list of activities and priorities, and the consultant was not asked specifically to develop a list of follow-up activities. Consequently, the following suggestions, based on the workshop results, are provided for reference purposes only.

1. The LAC will need to review the materials presented in the workshop to make the surveyors scoring of the accreditation standards more consistent and to ensure there is not large variation among surveyors. Additional training of the expert surveyors is needed to set a norm for reviewing and rating of specific standards.

2. The LAC should develop the list of those institutions to be reviewed in 1998. It then should begin to conduct seminars and other educational and training programs for hospital chiefs and other key health facilities that will be inspected, to allow them sufficient time to prepare their institutions and staffs for inspection.

3. The LAC should develop an advisory group of chief physicians, possibly eight to ten chiefs from different levels of hospitals, to review and advise on the practicality of the various licensing and accreditation standards and process in the real world.

4. The LAC will need to begin to think through and plan the process and standards for polyclinics and FGPs in the new insurance environment. The MHIF is ready to begin paying FGPs on a capitation basis, and the LAC will need to begin to develop and implement L&A in these other types of health facilities.

5. The LAC and the MHIF will need to closely monitor the behavior of the L&A reviewers (inspectors and surveyors) to ensure that personnel with positive, helpful, and educational attitudes and behavior are being utilized and that personnel with negative, punitive, and non-educational behavior are removed from the accreditation process.

5.7 Seminar Outputs

The outputs from the one-day workshop to review the existing process of standards for licensing and accreditation produced considerable discussion on the role of L&A in health reform, focusing on the specific activities in both licensing and accreditation as they relate to rationalization of services and facilities. The group is aware that they must assist the MOH to close some facilities and to improve others. If L&A is to be successful, it must focus upon the job of matching existing resources to needs.

6.0 EVALUATING FOLLOW-UP

The consultant, during his visit and in this report, has made a number of receommendations for follow-up activities. The process of monitoring (in this case, follow-up progress) normally involves a comparison of actual accomplishments against the original plans. Discussion centers around what went well and what did not, as well as why they did or did not go well, and, finally adjusting future plans. Often, a report is written to document the "lessons learned," and it is shared with colleagues and other similar projects, so that they can adopt successful practices and avoid those that .

With respect to the consultant's findings and recommendations, the following questions should be asked:

1. Were the findings and recommendations reviewed in a timely manner with Almaty, Bethesda, the Oblast Health Department, and USAID? A period of six to eight weeks (December 15-30) would be considered timely, possibly eight to ten weeks with translation difficulties (January 30).

2. Were decisions taken in a timely manner with respect to the recommendation, and were any follow-up studies conducted to verify or develop further? A period of three to four months (February 15) would be reasonable.

3. Were the findings and recommendation on the L&A process reviewed and acted upon in a timely manner? Was action taken?

4. Were the activities requested to be completed between trip six (September) and trip seven (January) actually completed?

ANNEX 1 TRIP ACTIVITIES

September 27/28: Traveled from Philadelphia to Almaty and Bishkek via Frankfurt.

September 29/30: Met with Sheila O'Dougherty and Almaty office staff; traveled from Almaty to Bishkek and met with Bishkek staff to review plans and priorities.

September 31: Met with L&A Chairman, Asanaly Saadakbayevich and key counterparts to review status of L & A plans and projects.

October1-5: Met with Bishkek staff and counterparts to review FGP development, hospital association developments, and Kassa developments. Met with key L&A counterparts to review ideas for workshop presentation and dry run for L&A hospital review. Met with Issyk-Kul counterparts to review FGPA and related Bishkek roll-out issues. Worked on a variety of project areas as well and traveled to Karakol from Bishkek.

October 6-13: Met with Karakol counterparts and worked on a variety of project areas. Reviewed FGP sites and MHIF developments. Traveled to Bishkek from Karakol and met with Bishkek staff.

October 14-16: Worked with FGP, L&A, and Kassa counterparts. Conducted L&A workshop for counterparts. Worked on FGP and L&A activities and traveled from Bishkek to Almaty.

October 17: Traveled from Almaty to Philadelphia via Frankfurt.

ANNEX 2 PROPOSAL FOR FGPA BOARD/MANAGEMENT STRUCTURE

This paper outlines the key parameters to be discussed and decided upon for the formation and implementation of the new Issyk-Kul Family Group Practice Association. The Association is a legal entity in Kyrgyzstan and is formed as an association to foster and protect the interest of its membership, and its goals include improving the quality and cost effectiveness of primary care delivery to the population.

BOARD OF DIRECTORS

The major authority and responsibility for the association lies within the Board of Directors. The group will consist of nine members, including the Chairman. The membership of the Board will be made up of physician members of the association. All nine members will be voting members, but the board may have non-voting members, including various management positions within the association. (For example, the Director of Finance may be a member of the Board, but may not be a voting member.)

BOARD COMMITTEES

The Board will have the normal range of board committees, which may be finance/payment, quality, public relations, and others as the association may find necessary over time.

MANAGEMENT AND PERSONNEL

1. The Association will be headed by a Chief Executive Officer (CEO), whose title will be President, and who will also fulfill the position of Chairman of the Board of Directors.

2. Reporting to the CEO will be the following functional areas and positions:

- Practice Management: Family Group Practice Manager Supervisor/s, who will be responsible for the 28 PMs and the business operations of the 83 FGPs in the oblast;

- Family Planning and Infectious Disease: Trainers and consultants who deliver educational and training materials and information to the oblast physicians and the population;

- Training Center: The Center of Excellence with trainers and consultants who educate and train family physicians;

- Quality Management: Experts in FGP quality assurance and quality management;

- Finance and Accounting: Experts in finance, accounting, and payment issues.

RELATIONSHIPS WITH OTHER ORGANIZATIONS

The FGPA will have a number of coordinating activities and functions with the following organizations:

- The Oblast Department of Health: This is the major health authority in the oblast and will have direct oversight responsibility in the early stages of the project, which will lessen over time as the FGPA becomes more independent.

- The Oblast Mandatory Health Insurance Fund: This is the major health funding authority in the oblast and will have long-term funding responsibility and oversight of the FGPA.

- The Zdrav*Reform* Program: This is the major health developmental organization in the oblast and will have direct start up operating funding and responsibility and authority for the FGPA in the short term, which will phase out over time.

- The Social Insurance Fund: This is the major health tax collection and distribution organization in the oblast and will have coordination responsibilities with the FGPA.

ANNEX 3
PROPOSAL FOR JOINT COMPUTER/SHARED SERVICES OPERATION

This paper outlines the key parameters to be discussed and decided upon for the formation and implementation of the new Issyk-Kul Joint Computer/Shared Services Operation (JCSSO). The goal of this operation is to serve the information system (IS) , statistics, and payment needs of both the Oblast Health Department (OHD) and Oblast Kassa Zdarovia (OKZ) and to provide a number of shared services and common data systems to these two organizations .

OBJECTIVES:

- To provide one common database for all data and information required by the Oblast Health Insurance Fund (OHIF), OHD, Oblast Social Insurance Fund (OSIF), OKZ and related organizations in order to budget and pay for health services at health care facilities (Family Group Practices, polyclinics, and hospitals) in the Issyk-Kul oblast;

- To provide accurate and timely data and information to the OHD and OKZ on health facilities , utilization of health services, and payment information for health services; and

- To provide information to the OSF and other local and national organizations requiring data and information on health insurance payments to health facilities, health statistics, health facilities utilization, and other health and financial information.

LOCATION, FUNCTIONS AND STAFFING

The JCSSO will be located in two rooms on the fourth floor of the Municipal Polyclinic in Karakol. In order to support the payment of health services at FGPs, polyclinics, and hospitals, the functions of the JCSSO will be as follows:

- Information Systems will include all data elements, software, hardware, related equipment, and personnel required for input/output, repair and installation. It is estimated that the existing three positions presently budgeted will be required.

- Accounting/Finance/Payment Systems will include all related data and information required for accounting, finance and payment for health services. This will include both budget and actual statistics, revenues, and expenses as well as assets and liabilities. It is estimated that one position will be required to start up the operation of this function, with some additional positions being provided by the OHD.

- Statistical Systems will include all related information on epidemiological, clinical, quality assurance and related subsystems to provide information It is estimated that

three positions will be required to start up this function, with some of the positions coming from the OHD.

SUPPORTING DATA AND INFORMATION

One major objective of common database systems is to support the OHD and the OKZ with an effective and efficient IS. The task of designing, developing, and implementing the required data systems is a large one. Outlined below are some of the data and information which will be required for each major component of the health system:

- Family Group Practices will be required to input timely and accurate data and information on enrollment, patient identification, workload, referrals to specialists and paraclinical services, referrals to hospitals, ICD-9 disease information, and other data as required by the OHD and OKZ, for effective payment for health services.

- Polyclinics will be required to input timely and accurate data and information on patient identification, FGP identification, workload, referrals from FGPs, referrals to hospitals, admissions to hospitals, services provided to patients, prices for services provided, ICD-9 disease information, and other data as required by the OHD and OKZ

- Hospitals will be required to input timely and accurate data and information on patient identification, FGP identification, polyclinic identification, workload, referrals from FGPs, referrals from polyclinics, types and number of cases by clinical disease category, and other data as required by the OHD and OKZ.

RELATIONSHIPS AND REPORTING

The JCSSO will be responsible to both the OHD and the OKZ, and will have day-to-day reporting responsibility to the Zdrav*Reform* Program during the initial start up stages of the operation.

ANNEX 4 DRAFT PROPOSAL FOR FGP CAPITATION FUNDHOLDING

This paper outlines the key parameters to be discussed and decided upon for the formation and implementation of the new Issyk-Kul FGP Capitation Fundholding System.

OBJECTIVES OF THIS PROPOSAL

The developmental objectives of this paper on the new capitation fundholding system are:

- To provide the necessary information on all of the various aspects of capitation fundholding for FGPs to the large number of interested parties (MOH, MHIF, World Bank, US Agency for International Development, OHD, OKZ, OSF, etc.);

- To list and to explain the various options which have been considered for implementation;

- To recommend one of the options for implementation;

- To ensure all parties of the sustainability of development of the recommendation.

STAGES/PHASES OF IMPLEMENTATION

The process of implementing the new capitation funding for FGPs will be phased in over a period of twelve months during calendar year1998, and is recommended as follows:

- The government will provide a new line item in the 1998 budget process that will allow for primary care expenses, specifically FGP related health expenses.

- The FGPs will begin to receive some partial funding in the form of an initial capitation payment based on the number of enrolled population in the FGP, but the payment will be in the form of reimbursing for direct, variable costs only (see below).

- Effective January 1, 1998, the 83 FGPs in Issyk-Kul oblast will be funded by a capitation fundholding method for part of their "internal," direct, variable costs (primarily salaries, benefits, and other direct expenses (see discussion below).

- Effective April 1, 1998, the 14 Karakol City FGPs will be funded on a "partial" capitation fundholding system to include some outpatient referral expenses (see below), and the remaining 69 Issyk-Kul FGPs will follow later in 1998 based on a schedule to be determined.

CALCULATION OF THE "INTERNAL" FGP OFFICE EXPENSES

The overall strategy for implementation will be based on a phased approach starting with internal, direct expenses and continuing to cover some fixed expenses, and will be as follows:

- The first payment will cover only direct, variable expenses of the FGPs (salaries and related benefits for physicians, nurses, other medical and support personnel, and practice managers, and may cover some of the expense of materials, supplies, and related direct operating expenses.

- The second payment will begin to cover some of the indirect, fixed expenses of utilities, rent, and overhead.

- Future payments will be adjusted to cover risk adjustment, such as age, sex, and chronic illness of the population covered, and are in the process of development.

- Calculations for outpatients as partial capitation will be developed to begin to cover the 14 Karakol FGPs on April 1, 1998, with review and discussion prior to that date.

- The various costs of operation of the FGPs will be broken into a series of financial schedules that will separate the 25 FGPs located inside polyclinics from the 58 FGPs located outside of the polyclinics.

- Each schedule will also separate for each FGP the internal direct cost (salaries, etc.) from the internal indirect cost (utilities, rent, etc.) so that a review of the cost differences can be highlighted and discussed.

MOF/TREASURY/OHD ACCOUNTING, FINANCE, AND FUNDS FLOW

The necessary accounting and financial transactions to allow these changes to take place are under development. The description of the accounting, finance, audit, internal control, and funds flow process will be developed in the next month, which will outline the exact accounts, sub-accounts, bank accounts as well as the approval and cash flow policy and procedure. With the new line item in the budget for FGP primary care expenses, the various responsible parties will need to budget and to account for the expenditure of funds related to the operations of the FGPs.

ANNEX 5 REFERENCES

A. BIBLIOGRAPHY

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Pavlock, E.J., "Financial Management of Medical Groups, Center for Research in Ambulatory Health Care Administration," 1994.

B. PERSONS CONTACTED

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C. ACRONYMS

FGP	Family Group Practice
FGPA	Family Group Practice Association
IDS	Intensive Demonstration Site
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCSSO	Joint Computer/Shared Services Operation
L&A	Licensing and Accredition
LAC	Licensing and Accreditation Commission
(M)HIF	(Mandatory) Health Insurance Fund
MIS	Management Information Systems or Medical Information System
MOF	Ministry of Finance
MOH	Ministry of Health
OHD	Oblast Health Department
OKZ	Oblast Kassa Zdarovia: Cash-holding agency, MHIF
PM	Practice Manager
SOW	Scope of Work
USAID	United States Agency for International Development

ANNEX 6 CONSULTANT SCOPE OF WORK

NAME: George P. Purvis
DATES OF VISIT: September 27-October 18, 1997
COLLABORATING ZDRAVREFORM MEMBERS: Sheila O'Dougherty
WORK SITES: Bishkek, Kyrgyzstan

TASKS:
1. Monitor the full implementation of the Licensing and Accreditation Process.
2. Finalize implementation of Stage II of FGPs, including budgeting, accounting, banking, and clinical information systems, management and reporting;
3. Continue training of L&A counterparts in Accreditation methods and practices.
4. Continue implementation of the outpatient payment systems including fundholding and the outpatient fee schedule.
5. To conduct working groups as necessary for FGP, Kassa, and L&A counterparts.

OUTPUTS:
1. Report summarizing progress on implementation of the L&A process;
2. Recommendations on the development of the FGP implementation process;
3. Materials for any workshops on Licensing and Accreditation.
4. Findings and recommendations for the Karakol IDS.

ANNEX 7: WORKSHOP EXHIBITS

EXHIBIT 1

AGENDA FOR L&A WORKSHOP
OCTOBER 14, 1997
BISHKEK, KYRGYZSTAN

I. INTRODUCTION:
Objectives and Role of the Consultants
Review of Materials to be Covered

II. HEALTH CARE REFORM IN THE NEW ENVIRONMENT
The Strategic Thinking Process
Mission and Vision
Future L&A Activities
Resources and Time Constraints

III. L & A LESSONS LEARNED IN OTHER COUNTRIES
International Lessons Learned
Concerns and Problems to Discuss
Questions about the L&A Process

IV. HEALTH FACILITY LICENSING STANDARDS
Questions about the Process and Response
Examples of Clear Written Standards
Examples of Compliance Measures

V. HEALTH FACILITY ACCREDITATION
Review of the Overall Process
Reaction of Hospitals Reviewed
Review of Expert Evaluation Forms
Review of Scoring
Final Survey Report

EXHIBIT 2

INTERNATIONAL LESSONS LEARNED - ACCREDITATION

1. EDUCATIONAL AND NON-PUNITIVE

2. FORM AN ADVISORY GROUP OF CHIEF PHYSICIANS

3. FOCUS UPON LONG TERM CONTINUOUS QUALITY IMPROVEMENT

4. DESIGN TO BE FLEXIBLE AND EASY TO CHANGE (20/80)

5. STANDARDS TO BE IN CLEARLY WRITTEN, STATEMENT FORMAT

6. FOCUS ON KEY QUALITY AREAS (20/80)

7. OBJECTIVE AND EASY TO MEASURE CONSISTENTLY

8. REDUCE SCORING SUBJECTIVITY THROUGH TRAINING OF SURVEYORS

9. MAKE IT EASY TO COMMUNICATE

10. EDUCATE, EDUCATE, EDUCATE, . . .

EXHIBIT 3

LIST OF ISSUES/CONCERNS

1. COMPLEXITY OF WHOLE PROCESS

2. SUSTAINABILTY OF EFFORT (TIME, MANPOWER REQUIRED)

3. CONSISTENCY OF SCORING

4. PRACTICALITY AND COMMUNICATION

5. TRAINING AND EDUCATION

NOTE: The World Bank Report contains a translation of the L&A Manual.